WORKPLACE VIOLENCE AGAINST NURSING PERSONNEL

A Literature Review

Tuuli Luoto-Korhola
Susanna Niskanen

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JYVÄSKYLÄN AMMATTIKORKEAKOULU
JAMK UNIVERSITY OF APPLIED SCIENCES

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Title
WORKPLACE VIOLENCE AGAINS NURSING PERSONNEL

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Tutor(s)
JAKOBSSON, Maarit YABAL, Anneli

Abstract

The purpose of this study was to explore how many nurses, or what percentage of nurses, have experienced workplace violence perpetrated by patients or visitors, and what type of violence is directed at nursing staff working in medical hospitals in different countries. Another purpose was to explore the nature of debriefing and support received by nurses who had been victims of workplace violence. The aim was for the results to provide useful information on workplace violence experienced by nurses and contribute to evidence-based practice. The results of the review could be utilized by nursing students, registered nurses, licensed practical nurses and management working in the healthcare field.

Electronic search produced eighteen scientific articles, with information from five different countries that were selected for the review. The statistical data from the different studies had variations, but most supported the facts that relatively large portion of nurses encounter workplace violence and that verbal violence, in its' many forms, is the most common type of violence encountered. Physical violence experienced can range from physical threats to rape and assaults with deadly weapons. Weapons most commonly used are hospital equipment, medical equipment and furniture.

The findings concerning support received by nurses after a violent incident showed that peer support was, in many cases, the only support received. The nurses feel unsupported by the management and in some cases, are even afraid of the management reaction to a violent incident. This fear keeps nurses from reporting the incidents and from getting the needed help to deal with the consequences.

The issue of under-reporting affects all aspects of studies done on workplace violence in healthcare. Clear reporting instructions and standard definitions of violence will help to produce more accurate reports on the phenomena. To reduce the harmful consequences of workplace violence, nursing staff needs to become aware of their rights to defend themselves and the right to receive proper support after a violent incident.

Keywords
Workplace violence, assault, support, de-briefing, nursing, hospital, literature review

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LUOTO-KORHOLA, Tuuli
NISKANEN, Niina Susanna

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Tiivistelmä

Tämän opinnäytetyön tarkoitus oli selvittää kuinka moni sairaanhoitaja on kohdannut työpaikkaväkivaltaa potilaiden tai potilaiden perheenjäsenien taholta. Tämän lisäksi selvitettiin minkälaista väkivaltaa hoitajiin kohdistuu ja minkälaista tukea hoitajat saavat väkivaltakokemusten jälkeen. Työssä keskityttiin työpaikkaväkivaltaan, mikä on ongelma sairaaloissa eri puolella maailmaa. Katsauksen luonteen vuoksi mielenterveyslaitokset poissuljettiin. Opinnäyte työ toteutettiin kirjallisuuskatsauksena. Tavoitteena oli tehdä katsaus jossa olisi tämänhetkistä tietoa hoitajiin kohdistuvan työpaikkaväkivallan yleisyydestä ja luonteesta, sekä heidän saamastaan tuesta. Katsaukseen kerättyä tietoa voidaan hyödyntää näyttöön perustuvassa hoitotyössä.

Elektroninen tiedonhaku tuotti kahdeksantoista tieteellistä artikkelia viidestä eri maasta. Tilastollisissa tiedoissa oli eriävyyksiä, mutta kaikista tutkimuksista kävi ilmi, että suuri osa hoitajista kohtaa työpaikkaväkivaltaa. Verbaalinen väkivalta on tyypillisin väkivallan muoto. Hoitajiin kohdistuva fyysinen väkivalta pitää sisällään kaikkea fyysisestä uhkailusta aina raiskaukseen ja aseelliseen pahoinpitelyyn. Yleisimmin käytetyt aseet ovat sairaalan välineet ja huonekalut.

Lähteiden mukaan vertaistuki on monissa tapauksissa ainoa tuki mitä hoitajat saavat väkivaltatilanteen jälkeen. Hoitajat eivät koe saavansa tukea esimiehiltään. Joissain tapauksissa esimiesten suhtautuminen väkivaltatapauksiin aiheuttaa pelkoa hoitajissa, mikä on syynä tapausten raportoimatta jättämiseen.

Väkivaltatapausten vähäinen raportointi vaikuttaa kaikkiin aiheesta tehtyihin tutkimuksiin. Selkeä raportointiohjeistus ja selkeät määritelmät siitä mitä työpaikkaväkivallan käsite pitää sisällään auttaisi tuottamaan tarkempaa tutkimustietoa aiheesta. Hoitohenkilönkunta tietoon tulisi saattaa heidän oikeutensa puolustautua väkivaltaa vastaan. Heidän on myös tiedostettava oikeutensa saada oikeanlaista tukea väkivaltatilanteen jälkeen.

Avainsanat (asiasanat)

Työpaikkaväkivalta, pahoinpitely, kriisiapu, hoitotyö, sairaala, kirjallisuuskatsaus,

workplace violence, assault, support, de-briefing, nursing, hospital, literature review

Contents

1 Introduction

Working in the social- and healthcare fields increases the persons' chances of becoming a victim of violence or aggression (Lehestö, Koivunen, & Jaakkola 2004, 86). The British Crime Survey states that nurses have 5% risk of being physically assaulted at work. This number is 4 times higher than national average. (Badger & Mullan 2003). According to the United States Bureau of Labor Statistics, 60% of all workplace assaults occurred in health care and most of these assaults were perpetrated by patients (Gates, Gillespie, & Succop 2011). Despite these figures violent incidents are not always taken seriously and quite often these incidents are not report to the police or further investigated (Sajama 2012). Workplace violence can impact the healthcare field in many ways. The violent situations or dealing with threatening persons can be very stressful for the professional. (Lehestö et.al. 2006, 86-89). The monetary cost of one single assault on a registered nurse, according to one study, is $31 643 (Gates et.al. 2011). Furthermore the nursing shortage is expected to increase in the future. The recruitment and retention of qualified staff could be deterred by workplace violence. (Howerton Child & Mentes 2010).

The choice of the theses' topic was, in part, influenced by the authors' own experiences of dealing with aggressive and threatening patients, witnessing incidents of workplace violence and seeing how these incidents were reported and how the aftermath was handled. These experiences made the authors curious as to how many nurses experience workplace violence, the nature of this violence, and do the nurses receive support after violent incidents.

The aim was for the results to provide useful information on workplace violence experienced by nurses and contribute to evidence-based practice. The results of the review could be utilized by nursing students, registered nurses, licensed practical nurses and management working in the healthcare field.

2 Violent behavior and workplace violence

There are many definitions for violence and what constitutes violent behavior. Merriam-Webster online dictionary defines violence as “a: exertion of physical force so as to injure or abuse, b: an instance of violent treatment or procedure”. In some instances other words are used when talking about violent behavior, such as aggression, aggressive behavior, harassment, threats or threatening behavior and physical or verbal abuse (for example; Roche, Diers, Duffield, & Catling-Paull 2010, Wiley 2007). The World Health Organization has defined violence as: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group, or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.” (WHO 2002a). This description is much broader than the one offered in dictionaries. It includes not just physical violence, but also other aggressive behaviors even if they do not cause physical harm. The WHO (2002a) goes even further by defining that the “use of power” includes threats and intimidation, not just physical force. It should also be noted that the WHO (2002a) uses the word “intentionally” only to describe how the power or physical force is used, it does not state anywhere “with intention of causing” a one outcome or another. This helps to include into this definition acts where the person doesn’t have a specific intent to cause damage. For example a person may be prone to aggressive behavior due to underlying pathology, such as brain damage, and their violent behavior does not have a conscious malicious intent (Badger & Mullan 2004). All in all the WHO (2002a) defines violence in relation to health and well-being of individuals, regardless of what are the intentions or what might be culturally accepted behavior.

Workplace violence could be defined as any of the incidents in WHO’s (2002a) definition of violence, that take place in the workplace. However some of these incidents, even though they originate from the workplace, might take place when the worker is traveling to and from work, for example a stalking by someone first met in the workplace. The WHO also has a definition for workplace violence that will be used in the theses. They define it as “Incidents

when staff members are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health". (WHO 2002b) This is a broad definition that covers many aspects of workplace violence because it includes the work commute and does not make a distinction between verbal and physical violence.

As the definitions of violence vary in the different reports and articles, in this theses, the WHO's definition will be used, and the reference material that fits in the WHO's definition of violence and workplace violence will be included.

2.1 Legal aspects of workplace violence

In many countries, for example in Finland, United Kingdom, United States and Australia, there are workers' safety laws in place. These laws mandate the employer to provide a safe work environment and to provide safety plans and protocols in case of situations that pose a threat to the employee safety. (Työterveyshuoltolaki 21.12.2001/1383; Australian Government: Work Health and Safety Act 2011– c2011A00138; Health and Safety Law 2009; McKoy & Smith 2001).

In United States OSHA, the Occupational Safety and Health Administration, has a General Duty Clause according to which employers are negligent if they fail to recognize and take steps to correct potential hazards. OSHA can and has fined hospitals where there have been numerous attacks on staff by patients. (McKoy & Smith 2001). Some states have increased penalties for assaults against nurses (Wiley 2007).

In 2011 in Finland the law regarding assaults changed to where all assaults that are directed to a person because of their work duties and the assailant is not a co-worker are now under general prosecution. This means that the victim doesn't need to state that they have a claim against the assailant. As long as the incident itself is reported, it will be investigated and prosecuted. (Laki rikoslain muuttamisesta 441/2011). Patient committed assaults towards healthcare staff would be included in this category, even if under the criminal

law the assault would be categorized as mild. Also in Finland the laws mandate that the employer is responsible for the employee safety and health (Työterveyshuoltolaki21.12.2001/1383). Employers are also responsible for making written safety plans regarding threatening situations (Pelastuslaki 29.4.2011/379).

Even with tightened laws and regulations in place assaults towards healthcare staff continue. One theory is that because of the under-reporting of the violent incidents, the strategies and legislation designed to minimize them will be flawed, because the data these strategies and legislations are based on is incomplete (Ferns 2006).

2.2 Workplace violence in healthcare

Violence can take place in any setting, and workplace violence can occur in any workplace (McKoy & Smith 2001). Research shows that violence in health care workplace is a long standing problem that is reaching epidemic proportions (WHO 2002b; Needham, Abderhalden, Halfens, Fischer, & Dassen 2005). According to the Finnish Union of Health and Social Care Professionals every 4th nurse has experienced violent behavior directed at them by a patient or patient's family (TEHY 2005). In United States it is estimated that nurses and healthcare workers are assaulted more often than any other group of professionals (McKoy & Smith 2001). Australian nurses experience workplace violence four times more than average employee and they have more violence related workers compensation claims than correctional officers and the police (Opie, Lenthall, Dollard, Wakerman, MacLeod, Knight, Dunn & Rickard 2010).

The violent behavior directed at nurse can be either direct violence, such as hitting or kicking, but it can also take more indirect forms. Threatening behavior is very common form of this indirect violence and can include yelling and cussing as well as breaking property and placing threatening phone calls and sending threatening messages by e-mail or text messages. The threats can also be directed at the nurse's family. (TEHY 2011).

Some of the most common forms of violence in a healthcare workplace are:

- holding, pushing and shoving
- hitting, kicking
- spitting, biting, scratching
- using a weapon, such as a gun, edged weapon or a blunt object
- threatening life or health
- sexual harassment
- public humiliation
- threatening with lawsuits or threatening to go to the press
- threatening family

(TEHY 2011, Gates & Kroeger 2002, Opie et al. 2010)

Violence leading to death seems to be less common. Data from United States Bureau of Labor Statistics from 2011 states that between 2003 and 2009, eight registered nurses were fatally injured at work. Four of the nurses died from gunshot wounds and the other four received different types of fatal injuries. (American Nurses Association 2012).

2.3 Cost of workplace violence

The cost of workplace violence can fairly easily be measured in monetary damages, but the non-monetary damages to the victim's morale, self-esteem and mental health are harder to measure. Some idea can be found in the studies that focus on mental health of nurses and quality of patient care after violent incidents.

In 2001 The United States Bureau of Justice Statistics estimated that workplace violence cost per incident was $250 000. This amount included lost time cost and legal fees. Workplace violence also leads to decreased quality of patient care, low staff morale, and increased staff absenteeism. Assaulted staff members have higher rates of substance abuse problems, and psychological issues such as posttraumatic stress disorder and anxiety disorder. (Howerton Child & Mentes 2010).

A study done in Minnesota in 2001 found that 344 nonfatal assaults cost healthcare employers estimated $5 885 448. These costs included medical expenses, lost wages, legal fees, insurance administrative costs, lost fringe benefits and household production costs. The cost per single assault on registered nurse was $31 643. It has also been found that 94% of nurses experience at least one Post Traumatic Stress Disorder symptom after a violent event and 17% have scores high enough to have probable diagnoses of PTSD. (Gates et al. 2011).

2.4 Nurses as targets of violence

Commonly service professions are at high risk of violence because of continuous contact with the public. Illness on itself is very stressful as is the uncertainty commonly associated with illness. Nurses are in contact with representatives of the public who are ill, confused, under stress, experiencing pain and feeling of powerlessness, they can also be under the influence of drugs or alcohol. These are all conditions that can increase the possibility of violent or aggressive behavior. In a situation where a person is deprived of individuality, dignity and become dependent on others for care can cause them to express themselves thru aggression. (Badger & Mullan 2004; Gates & Kroeger 2002; McKoy & Smith 2001; Wiley 2007).

Many workplaces prevent violence with access restrictions, but this does not work in a health care setting where many places have 24-hour open door access to patients and family and unrestricted movement of the public. In many cases, especially in the United States, public is able to enter healthcare facilities with weapons. (Wiley 2007; McKoy & Smith 2001).

Downsizing and cost-cutting measures can affect the safety of nurses in many different ways. Reports from several different countries mentioned the increased number of psychiatric patients in general hospital system as one reason that can increase the potential of violent incidents. There seems to be a trend of shifting to community-based, outpatient mental health care that has led to decrease in mental health beds. Such diagnoses as bipolar disorder, poor impulse control, schizophrenic delusions or hallucinations can result in

violent tendencies. The main concern with mental health patients and individuals under the influence of drugs is their unpredictable behavior. Poor staffing, high nurse to patient ratio, that is a problem in all areas of healthcare, is making it impossible for nurses to provide enough attention to patients and family members. This can also cause long waiting times in the emergency rooms. Both of these situations can cause stress and frustration that can lead to aggression. (Badger & Mullan 2004; Chapman, Styles, Perry & Combs 2010; Gates & Kroeger 2002; McKoy & Smith 2001; Needham et.al. 2005; Wiley 2007; Woolam 2007).

It should also be noted that in many reports nurses expressed their concern for the lack of education regarding violence prevention. It seems that nursing education does not equip them to deal with patient aggression or teach how to anticipate and prevent violent incidents. The lack of training can clearly increase nurses' risk of being assaulted both verbally and physically. (Badger & Mullan 2003; Chapman et al. 2010; Gates & Kroeger 2002; McKoy & Smith 2001; Needham et al. 2005; Wiley 2007; Woolam 2007).

2.5 Support for victims of workplace violence

Support after a traumatic event, in this case workplace violence, is vital. Traumatic event can cause excruciating stress, which unable the victim to participate in the duties at work and can paralyze the ability to function in a normal daily life. The victim might develop a psychological trauma which can break down the entire well-being if not taken care of properly with psychological support. (Saari 2000, 313-318; Ruishalme & Saaristo 2007, 86-87).

2.5.1 Psychological first aid

A traumatic event is followed by a psychological shock phase. This is a state in which our mind is protecting us from something too horrible to handle. (Saari 2003, 42). The form of support used in these situations is called

psychological first aid. First aid given is pure support instead of active help. This form of support can be given by anyone in the very beginning of the situation.

The difference between professional and “lay” helper is that professionals should be able to recognize the space the victim needs for his/her thoughts and emotions. Professional helper does not give advice or even comfort but listens to the victim and therefore allows the victim to react in the most natural way for him/her. (Saari 2003, 42, 142-147).

2.5.2 Defusing

Defusing is a form of psychological support given in a shock phase. Defusing session ought to happen as soon as possible after the traumatic event. A group of people that were a part of the event are gathered to “defuse the bomb” which is the inner status of these people. The goal of this method is to defuse the upper most feelings in organized and centralized manner. These defusing sessions are organized and directed by people who were not involved in the particular traumatic event. Sometimes crises workers are called in to give the session but, especially in organizations in which defusing is used often, members of staff are trained to lead the defusing sessions. This is often used among police, hospital staff and rescue professionals. (Saari 2003, 149-150).

2.5.3 Debriefing

Debriefing is a group form intervention method used in a situation of sudden crises. This method is used by the professionals in the field of crises work. In Finland, one needs to have training in crises- and catastrophe work and training to use debriefing method to have qualification to use debriefing as a support method. The goal is to organize occasion, guided by the professionals, to go through something out of the ordinary, to foster the beginning of grieving and to support and understand one´s own feelings as

well as others involved. The “aftermath” ought to take place in 1-3 days after the shocking situation. (Lönnqvist 2005, Saari 154).

Psychological debriefing has four essential goals; facing the reality, going through the psychological reactions, enhancing the social support and normalizing the reactions and preparing oneself for the upcoming reactions.(Saari 2003, 154-169).

3 Purpose, aim and research questions

The purpose of this study was to research how many nurses, or what percentage of nurses, have experienced workplace violence perpetrated by patients or visitors, and what type of violence is directed at nursing staff working in medical hospitals in different countries. Another purpose was to explore the nature of debriefing and support received by nurses who had been victims of workplace violence. To achieve this goal, a literature review was conducted. In this review information from relevant scientific papers and reputable articles is gathered and synthesized.

The aim was for the results to provide useful information on workplace violence experienced by nurses and contribute to evidence-based practice. The results of the review could be utilized by nursing students, registered nurses, licensed practical nurses and management working in the healthcare field.

Based on these objectives and aims the research questions are:

- How many, or what percentage of nurses experience workplace violence perpetrated by patients or visitors, and what type of violence is directed at nursing staff working in medical hospitals?

- What type of debriefing and support did nursing staff receive after a violent encounter at work?

4 Conducting the literature review

In this thesis the method in use is literature review. The thesis is a combination of narrative review and systematic review because a lack of detail in the information used, though the principles of systematic review methodology are followed to an extent.

4.1 Principles of literature review

The narrative review is a collection of information made by specialists of a specific field with a specific point of view. The search, evaluation and processing of the material is not necessarily profoundly documented and therefore the reader of the review cannot evaluate these factors. (Johansson & Axelin & Stolt & Ääri 2007, 4).

The systematic review is a secondary research of already existing precise and selected researches. Systematic review is directed on researches done in a specific period of time and therefore needs to be updated in the course of time to maintain the relevance of it. The difference of systematic literature review compared to other literature reviews is the specific purpose and the particularly precise process. Materials for the systematic review need to be carefully chosen and collected followed by a systematic evaluation and synthesis. Only the relevant and most accurate researches are included to the systematic review. The search process should be reported in sufficient detail to enable repetition. This reduces the risk of flaws and minimizes bias. (Johansson et al. 2007, 4-5; Centre for reviews and dissemination 2009).

Roughly the systematic review can be divided into three parts. First part includes the planning of the review, second part is the actual making of the review including the search, analysis and synthesis. The third part is the reporting the review.

While planning the review previous researches are studied, the need of the review is defined and the research plan is prepared. After creating the study questions, the methods of making the review are chosen. The questions set ought to be clear therefore the answers provided to the questions will be meaningful to the review. A clear set of objectives with pre-defined eligibility criteria for studies, researches and articles will outline the study questions. (Johansson et al. 2007, 4-6; Center for reviews and dissemination 2009; Cochrane Handbook for Systematic Reviews of Interventions 2011).

The systematic review proceeds according to the study plan by finding and selecting the information needed. Analysis and synthesis of the data proceed step by step and the quality of the papers is assessed. Synthesis of the outcomes is performed and assessment for the risk of bias. All the phases of the literature review are recorded and reported to ensure the possibility of repetition. The very last phase is the reporting of the outcomes and drawing a conclusion. (Johansson et al. 2007, 4-7; Center for reviews and dissemination 2009).

4.2 Literature search

The electronic article search was conducted 4th April 2012. The keywords are derived from the study questions formulated. The keywords used in the search made in English were; violence and workplace and nurses. The databases used to carry out the search were Cinahl (Ebsco) and Pubmed. The electronic search was limited to the time period between January 2000 and April 2012. Other criteria limiting the search were that the articles had to be available as free full text and the articles were published in academic journals. The search produced altogether 245 articles. Duplication of articles was not exclusion criteria at this point. Another search was performed to certain Finnish websites as well including Finnish nurses union TEHY, the practical nurses union SUPER and Statistics Finland. Keywords used in this search were; väkivalta and työpaikkaväkivalta. This search produced 220 articles and statistics. Duplication of the articles and statistics was not exclusion criteria at this point.

The searches were limited to articles published in Finnish and English; between January 2000 and April 2012.

4.3 Article selection

When choosing the articles, the predefined inclusion and exclusion criteria, as stated in Table 1., formed the basis for the study selection. The articles were to address the topic of workplace violence against nursing personnel in the settings of a medical hospital. The perpetrators of violence were to be patients/clients and/or their family member or friends. The type of violence was not an exclusion criterion as long as the perpetrator was the patient/client or a family member. This excluded the articles discussing merely peer and lateral violence.

The focus of the review was to find out how much and what type of violence occurs on a ward in a medical hospital directed at the nursing staff. Therefore the articles exclusively concerning the settings of mental health wards and institutions and municipal care were not included to the review.

The second focus of the review was to find out if the nurses, who had experienced a violent incident, had received support and debriefing from their employers and/or co-workers. Therefore the articles discussing debriefing and support were included to this review. The articles in the review were selected from specific countries. These specific countries were selected because the search performed produced articles mainly from these countries. The articles included in to the review had all been published in scientific journals.

The inclusion and exclusion criteria for articles are listed in Table 1.

Table 1: Inclusion and exclusion criteria for articles

• Articles either in Finnish or English • Articles published in time period between January 2000 and April 2012 • Articles available as free full-text

- The perpetrators of violence are clients/patients and/or their family members or friends
- The victims of violence are nursing personnel in a settings of a medical hospital
- Articles concerning the support and debriefing of the nursing personnel after a violent incident
- Articles published in scientific journals
- Lateral violence not included
- The articles exclusively discussing violence in a settings of mental health wards or municipal care excluded
- Type of violence not an exclusion criterion

The first phase of article selection was mainly exclusion of the articles that did not fit into the criteria by the title. The exclusion criterion, at this point was, that the titles of the articles did not fit the inclusion criteria. Another exclusion criterion was that the articles needed to be published in scientific journals. After this phase of the selection there were 90 articles left.

The second phase of the selection was composed from reading through the abstracts of the 90 articles. The focus was to find out whether the articles match the more specific inclusion criteria.

At this point 40 of the articles did not meet the inclusion criteria and therefore were excluded from the review. Some of the excluded articles discussed mainly lateral violence which is not the focus of this review. Many articles were excluded because the settings discussed in the articles were specifically concerning mental health wards and institutions. Any duplication of the articles was not identified.

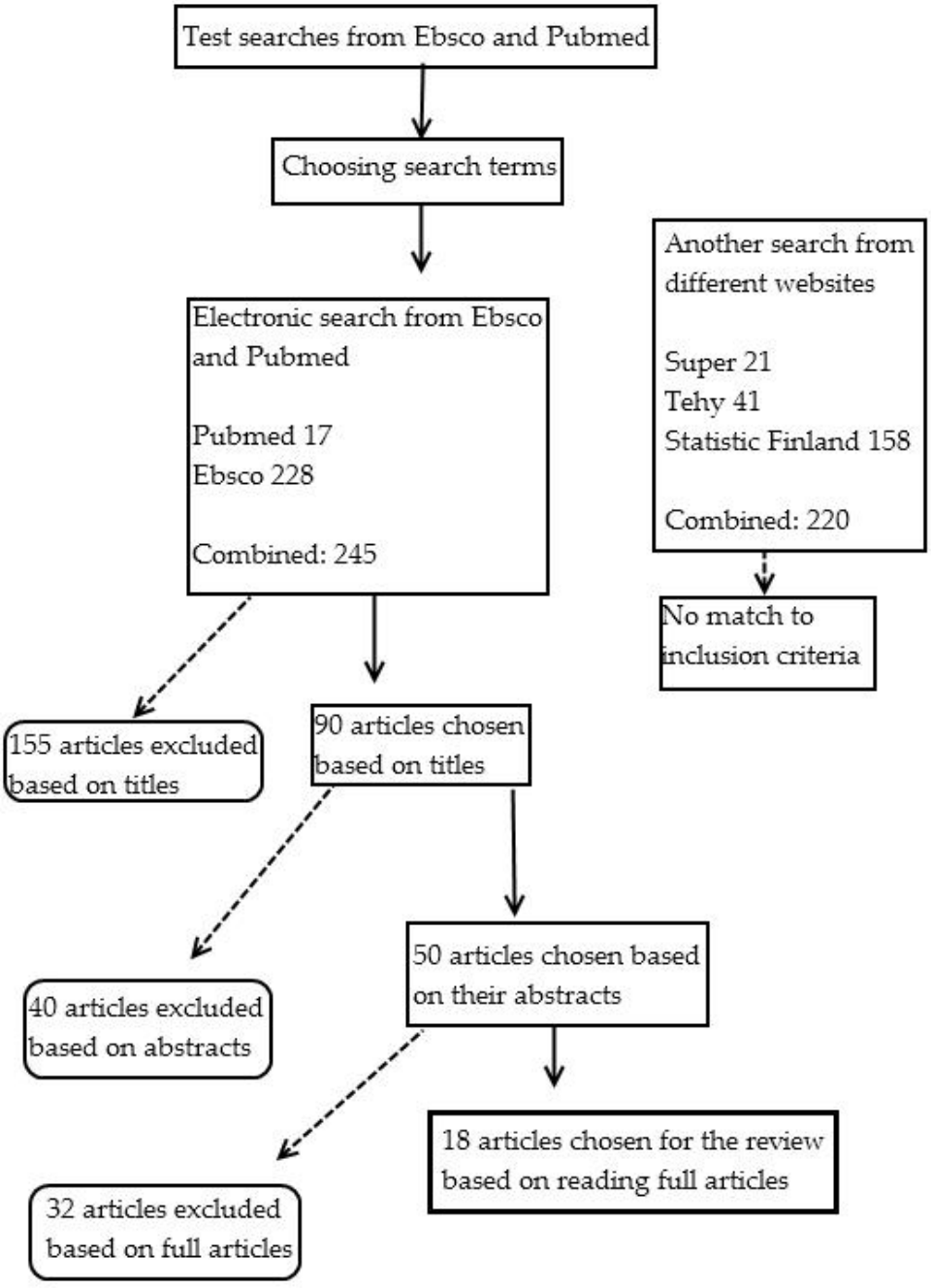
The remaining 50 articles chosen by the abstracts were to answer our study questions therefore these articles were read through carefully. The articles were studied to find out whether the inclusion criteria set was matched. While going through the process the quality of the articles was also assessed. The articles chosen for the review, the aim and purpose had to be represented

clearly. The entity of the articles needed to be coherent and the findings had to be stated in a clear manner. The studies chosen were to have relevance on the amount of violence experienced by the nurses and whether they receive any support after violent incidents.

The evaluation, whether the studies were able to give answers to the study questions was evaluated. At this point 32 articles were excluded. Excluded articles did not clearly state the facts needed to the review. Lateral violence was discussed in a lot of the articles and though it is a form of violence it has no relevance to this particular review. This left altogether 18 articles for the literature review.

Figure 1. features how the literature search and article selection was conducted.

Figure 1: The process of literature search and article selection



4.4 Analysis and synthesis

In order to get a general view of the data and enable comparison, the 18 articles chosen were read and tabulated. The overview of the articles included in the review is presented in the table in Appendix 1. The table shows the basic information regarding the articles, including the country of origin and the main information provided in the articles.

Narrative synthesis was used to report the findings. This is a textual approach that tells the story of the findings from the included studies and articles. The information from the studies is analyzed and described and a synthesis on the findings from the included studies and articles is developed. (Center for Reviews and Dissemination 2009).

To extract data from the articles for the review, the purpose outlined in research questions was followed. The data that emerged was organized in themes based on the research questions. The results were described using narrative synthesis. The study results and information extracted from the articles were compared, identifying similarities and differences. Generalizations and conclusions made were based on the literature.

5 Results

The review provides information on how many nurses, or what percentage of nurses have experienced workplace violence, what type of violence nurses encounter while working in hospitals, and what type of support they received after a violent incident. The results of this review show that large portion of nursing personnel encounter violent incidents during their working careers with verbal abuse and threats being the most common type of violence. The results also show that peer support is the most available type of support nurses receive after violent incidents. The issue of underreporting mentioned in most of the reference material affects the results.

All articles used in this portion of the study can be found in appendix 1.

5.1 Workplace violence experienced by nurses

13 articles were used in this part of the study. They were published between 2000 and 2011 in scientific journals. All the articles were published in English. Studies featured in the articles were conducted in Australia (n=6), Ireland (n=1), New Zealand (n=1), United Kingdom (n=1) and United States (n=4). Not all the articles used are strictly research papers, but they have required data to answer the research question and are from reputable publications. The results have been categorized by the type violence experienced. There is variation on how specifically the different articles categorize the type of violence, how many and what type of categories are used. Most articles however, differentiate between verbal and physical violence.

Some of the studies did not make distinction on who was the perpetrator of the violent incidents listed and some studies did not list specifically what type of setting the nurses were working in. These articles were used because they did not meet the exclusion criteria. The sample sizes and definitions of violence vary in the different studies. However the definitions all meet the WHO's definition for violence and workplace violence. Also the time frame in which the violent incidents occurred varies in the studies. Some studies focused only on last shifts, while others were interested in the previous three months and some went back as far as a year.

Most articles mentioned severe underreporting as one of the main issues affecting the reliability of all studies done on this subject. (for example McKenna, Poole, Smith, Coverdale, & Gale 2003 and Gates et al. 2011). Gates et al. (2011) study talks about "gross" underreporting that is in part due to the "the persistent perception that assaults are part of the job". Wiley (2007) used a quote from an earlier report that stated that nurses don't always see the need to report assault or abuse if there has not been physical injury. There is large variation in the response rates of the studies used from 20.3% (Chovanec-Toy 2000) to 80.3% (Roche et al. 2010), with most of the studies

having a response rate from 30% to just under 50%. The low response rates seem to reflect the trend of underreporting.

5.1.1 Violent incidents in general

There were four studies that gave overall numbers on how many nurses had faced workplace violence within the study parameters. These numbers do not make a distinction on what type of violence was used. There is some variation, but all the Australian studies support quite similar numbers of close to 50% or more of nurses responding, experiencing workplace violence in the survey timeframe.

Study done in Tasmania in 2002 found that 63.5% of those who responded had experienced verbal or physical abuse in the four working weeks immediately prior to the survey. Patients or their visitors were the most common source of violence. The questioner was sent to all 6326 nurses registered with the nursing board of Tasmania at that time. The response rate was 38%. (Farrell, Bobrowski, C. & Bobrowski, P., 2006). This number is quite similar to another Australian study done in 2004. In this study, a random sampling of 3000 nurses from Queensland nurses union answered a questioner about workplace violence. They were divided into 3 different sectors depending on weather they worked in private sector, public sector in the aged care. Close to 50% of nurses working in private sector, and close to 60% in the other two had experienced some form of workplace violence in the 3 months prior to the survey. (Hegney, Eley, Plank, Buikstra, & Parker 2006). It should be noted that nurses working in private sector experienced less violence than those in public sector, even if the difference was not very large.

Two other Australian studies give slightly larger numbers. First a study in which 76% of general hospital nurses employed by rural health services had experiences of patient aggression within a three-month period (Hills 2008). Second study with similar results was published in 2009. In the study 113 nurses working in several areas of non-tertiary hospital in Western Australia participated in a survey of workplace violence over 12 month period. 75%

reported experiencing workplace violence in the past 12 months. 25% had experienced workplace violence weekly. (Chapman et al. 2010) Information from this study gives an idea on how common workplace violence is in the surveyed area, by giving data on how many nurses experience violence on weekly bases.

All these studies surveyed a relatively short time frame, from 4 weeks (Farrell et al. 2006) up to 12 months (Chapman et al. 2010) and so can't give accurate data on how many nurses experience workplace violence during their working careers.

5.1.2 Verbal- and emotional abuse and verbal threats

Even though there was variation in the number of nurses who experienced verbal violence, all the studies and articles that mentioned it, supported the fact that verbal violence in its' many forms was most common type of workplace violence.

The forms of verbal violence can be categorized in different ways. The Tasmanian study done in 2002 gives the most detailed categories and lists 12 different types of verbal abuse. Out of those who had experienced some form of violence, rudeness (82.1%), shouting (68.1%), sarcasm (64%) and swearing (61.9%), were the most common types. 26.4% had been verbally threatened with physical violence and 2.2% had had their family threatened. (Farrell et al.2006) Less detailed descriptions, but quite similar results came from The Maryland Nurses Association Workplace Violence Survey Report done in 2005. The survey had 378 respondents out of which 83% had experienced verbal violence. 72% of the Maryland nurses reported threats and intimidation. The threats were mostly against the nurses' person and their job security, but threats against their lives, their family and property were also made. (Distasio, Hall, & Beachley 2005).

The rest of the articles mentioning verbal violence also report quite large percentages of these incidents, with two exceptions. In Nebraska Nurses

Survey done in 2007 only 26% of those who responded reported verbal abuse**.** There were only 154 respondents who worked in various health care settings. The verbal abuse was the most common type of violence here as well. (Wiley 2007.) Another study with low verbal abuse/threat rates was done in New Zealand. The study was sent to registered nurses in their first year of practice, working in different healthcare settings. The response rate was 47% with 551 completed surveys returned. 35% of those who responded reported being verbally threatened. Another form of verbal abuse mentioned was racial comments and gestures reported by 16% of the respondents. (McKenna et al. 2003.) Hawaii Nurses' Association workplace violence report done in 2000 reports much higher numbers. This survey reported that 60% of respondents had experienced verbal abuse from patients. (Chovanec-Toy 2000). In one of the most recent surveys conducted by the Emergency Nurses Association, which is affiliate of the American Nurses Association, the results from January 2010 to January 2011 showed that 53.4 % of nurses working in emergency departments reported experiencing verbal abuse over a 7 day period. The most common form of verbal abuse was yelling and swearing at 89%. (American Nurse 2011).

Four more Australian studies report large percentages of verbal workplace violence. A survey of 94 randomly selected medical and surgical wards in 21 public hospitals in two Australian states found that up to 66% perceived threat of violence and up to 65% perceived emotional abuse. This survey was done between 2004 and 2006 and the data was collected in 7 consecutive days. (Roche et al. 2010). Even larger numbers came from a study assessing incidence of workplace violence in the remote area nursing workforce. 349 nurses participated in this study generating an overall response rate of 34.6%. In the 12 months preceding the survey completion, the violence most commonly experienced by the nurses was verbal aggression with 79.5% of nurses reporting these incidents. (Opie et al. 2010) The Chapman et al. (2010) study mentioned in previous chapter, reported 92% of the nurses reporting workplace violence (75%) experiencing verbal abuse.

Study conducted in Ireland in 2006 also reports larger percentages on verbal aggression. The Irish study surveyed nurses working in accident and

emergency departments and had a response rate of 46%. The survey used again a different form of categorization, listing non-threatening verbal aggression and threatening verbal aggression. 89.2% and 80.6% of the nurses, respectively, reported experiencing these forms of violence in past month, making verbal aggression clearly the most common form of violence in this survey as well. (Ryan & Maguire 2006).

5.1.3 Physical assaults and physical threats

The percentage of nurses with experiences of physical violence, or physical threats, vary from survey to survey. Lowest numbers are from Wells and Bowers (2002). In a systematic search and study of literature followed by a critical review, they found that data supported a figure of more than 9,5% of general nurses who work in general hospitals in the UK were assaulted in any one year. This includes both assaults with and without injury. In the study it was admitted that the findings were limited and the actual prevalence can only be estimated. (Wells & Bowers 2002). The study done in New Zealand has different categories of physical violence listed by severity of incidents. 29% of respondents had experienced physical intimidation, 22% had been a target of attempted physical assault, 29% had been physically assaulted but did not require medical attention and 4% had required medical intervention after physical assault. (McKenna et al. 2003). In Australian study done by Roche et al. (2010) up to 50% of respondents perceived physical violence. The Tasmanian study which lists several different types of assaults, reports 69.3% being struck with hand, fist or elbow and 46.1% being pushed or showed. These were followed by scratching, spitting, biting and kicking and hair pulling and restraining. (Farrell et al. 2006).

In the study done in Western Australia, 69% of the nurses reporting workplace violence had been physically threatened and 52% had been physically assaulted in the 12 month period (Chapman et al. 2010).The study done in Ireland also mentioned threatening physical aggression with 54.3% of respondents experiencing it in past month**.** Mild physical violence was

reported by 22.9% and severe physical violence by 2.8% of nurses. Another form of violence mentioned in the Irish study that could be considered physical, was destructive aggressive behavior with 45.7% of nurses reporting this. (Ryan & Maguire 2006). The Opie et al. (2010) reported study, also done in Australia had 28.6% of all respondents experiencing physical violence in the past 12 months. This study did not make distinctions on what type, or how severe the physical violence was.

The studies done in United States (n=4) show a percentage variations, but it is interesting to note that studies done in Maryland and Hawaii report exact same percentage of physical assault at 43% (Distasio et al. 2005 and Chovanec-Toy 2000). The Nebraska Nurses survey reports 11% of the respondents experiencing physical violence (Wiley 2007). This number in turn is similar to the Emergency Nurses Association survey which reports 12.9% of survey respondents reporting physical assaults, with grabbing or pulling being the most common form. (American Nurse 2011). Wiley (2007) report mentioned scratching and pinching being the most common type of physical violence.

5.1.4 Assaults and threats with weapons

There were four studies or articles that mention the use of weapons in threats or assaults and three of these list the different weapons being used, giving a more detailed picture of these type of incidents. The Tasmanian study mentions, as part of the physical abuse category, that 23.9% respondents had been struck with and object or had an object thrown at them (Farrell 2006). The study done by Chapman et al (2010), also conducted in Australia, reported that 38% of those who responded had been assaulted with a weapon. The most commonly used weapons were hospital equipment (32%), guns (6%) and knives (3%). (Chapman et al. 2009) The Nebraska Nurses Survey does not mention how many nurses had been assaulted, but it listed the weapons they had seen used. The two that were most seen being used were furniture (22%) and medical equipment (20%), followed by pen or a

pencil (15%), knife (4%) , gun (3%) and syringe (1%). (Wiley 2007) In these two studies it is evident that weapons mostly used are those already in the workplace, such as furniture and medical equipment, not ones brought there by the assailant.

The Maryland Nurses Association Workplace Violence Survey Report from 2005 gives the most detailed record of weapons nurses had been threatened with. It does not list number of actual assaults with weapons. 12% of those who responded had been threatened with a gun, knife, or other lethal weapon. (Distasio et al. 2005) Lethal weapon is in U.S. law defined as any firearm, device, instrument, material, or any other substance that is capable of producing great bodily harm or death from the manner it is used or intended to be used. (U.S. Legal 2001-2011) Other weapons used were ax, belt, cane, door, ink pen, scissors, walker, blood, spit, fists, furniture, telephone, rock and forceps. (Distasio et al. 2005).

5.1.5 Other types of workplace violence reported

There were three studies that listed forms of workplace violence not categorized separately in the other studies. The Australian study done by Opie et al. (2010) reports 31.6% of those who responded reporting property damage as one form of workplace violence, as did the New Zealand study with 17% having observed property damage in the study time frame (McKenna et al. 2003).

Different forms of sexual violence were listed in their own category by Opie et al. (2010), as well as Ryan & Maguire (2006) and McKenna et al. (2003). 22.5% reported sexual harassment, and 2.6% reported sexual abuse/assault in the report by Opie et al.(2010). Sexual assault/rape was reported by 8.6% of respondents of the Irish study and sexual intimidation/harassment by 11.8% of the respondents (Ryan & Maguire 2006). The New Zealand study reported larger percentage of verbal sexual harassment at 30%. 14% of those responding to this survey had experienced physical sexual harassment. (McKenna et al. 2003). Stalking was also mentioned as one form of workplace

violence. It was experienced by 4.9% of the respondents of Opie et al.(2010) study and 4% of the respondents of study done by McKenna et al. (2003).

The Irish study also mentioned mild violence against self, severe violence against self, suicide attempts and completed suicide attempts as forms of aggression witnessed by nurses. The percentage of nurses who witnessed these was 51.4%, 38.9%, 72.9% and 5.6%, respectively. These are forms of workplace violence affecting the nurses, even if they are not the direct targets in these incidents. (Ryan & Maguire 2006).

5.2 Support after a violent encounter

The articles chosen to answer the study questions mostly discussed about the type of violence and the amount of it. There was, however, some information concerning the “aftermath” which is support and debriefing. Over all the information received from the articles gave an overview of a situation that is multi-layered and very complex.

5.2.1 Reporting

The problem of violence in the field of health care is complex. According to the studies one of the biggest problems is under-reporting. Many of the articles chosen to the review identify problems behind under-reporting. An article by Gates & Kroeger (2002) lists many including that the nursing staff are not encouraged to report and in fact can be discouraged to do so. In addition to this nurses tend to feel that reporting is time consuming and not worth the trouble because it will not make a difference whether they do it or not. The management is not responding to the acts of violence though these are reported or there will be repercussions, to the nurses by the management, if the incidents are reported. (Gates & Kroeger, 2002).

An article by Roche et al. (2010) identified the fact that nurses tend to feel that reporting is an empty gesture for the lack of support after reporting a violent

incident. Another problem identified is lack of professional confidence. Nurses are afraid that their need of support can be interpreted as a failure therefore the fear of being a seen as a failure is behind the problem.

An article by McKoy & Smith (2001) identifies many reasons why nurses fail to report violent incidents. The fear of losing one´s job, a fear of being blamed for causing the assault and a fear of being accused of negligence and/or poor performance as a nurse are reasons among many listed in the article. In addition nurses are afraid they are seen incompetent or, in case they haven´t been physically injured during the assault, trouble makers. (Howerton Child & Mentes 2010)

An article by Howerton Child & Mentes (2010) also identified a fact that there is a lack of standard definition for workplace violence. This is yet another problem contributing to under-reporting. In addition to under-reporting is inadequate documentation, which can actually create even more workplace violence. Even when the incidents are reported the support is not obvious.

A study done in USA in 2005 reveals that in the majority of cases, nurses who reported incidents of workplace violence were not offered any type formal support, counselling or protection by the management. They were in fact asked not to notify the authorities and the incidents were left without investigation. The nurse victims often felt like they were doing something wrong reporting the incidents and it seem to them they were treated unfairly by the management and co-workers after reporting an act of violence against them. Another thing acknowledged by the authors of the study was that re-victimization of nurses creates a problem which can contribute to under-reporting. (Distasio et al. 2005)

5.2.2 Managerial support

An article by Jackson, Clare and Mannix (2002) discusses the problem of nurses being generally unsupported by their management. Though lateral violence is not a topic of the review, lateral violence by line managers against nurses must be seen as a part of the problem. The difficulty to find support

and comfort after a violent incident is great if the management is the main source of bullying at work.

Among most of the articles, the study by Jackson et al. (2002) recognizes that violence is believed to a part of the job, which creates environment that actually supports violent behavior. The study discusses the problematic situation of nurses asking support from their superior but not receiving it. One of the many reasons behind this problem according to the study is the fact that nurse managers do not have proper managerial skills. As a solution the study offers compulsory training for the managers to gain effective managerial skills and development of strong policies to protect staff against workplace violence. (Jackson et al. 2002).

An article by Gates & Kroeger (2002) identifies the lack of emphasis on prevention of violence by the management. The administration does not emphasize the importance of support nurses need after being assaulted, harassed or threatened. Counseling and other forms of support need to become a priority to the management and administration in this battle against workplace violence. The victims feel upset and let down by the management. This may actually cause problems and distress about going back to work after a violent incident. The nurse victims might also have concerns about dealing with job stress and feelings of being let down by their peers. (Gates & Kroeger 2002).

“Administrators are in a key position to confront the issue of nurse victimization, dispel myths and promote safety and sensitivity to injured workers”. (McKoy & Smith 2001.)

Participation of management is crucial to the reduction of workplace violence. Management and administration can influence by offering trainings against workplace violence and by organizing debriefing and support when it is needed. (Howerton Child & Mentes 2010).

In general, according to the articles, there is a great lack of support in the field of health care. After a violent incident the nurse victims are expected to return work immediately unless they are physically harmed. In many cases there is no formal or informal debriefing offered to the victim nurses. Victims are left

without attention, which may contribute to PTSD (post-traumatic stress disorder) symptoms. (Gates et al. 2011).

5.2.3 Peer support

Support can be received from peers as well and this seems to be, according to several studies, the most available source of support. An article by Farrell et al. (2006) provides a view that nurses are reluctant to report their experiences of aggression and make it official. Nurse victims are more likely to talk to their peers and seek help and consolation from co-workers. An article by Gates & Kroeger (2002) identifies similar view on how nurses cope with workplace violence.

Several articles indicate that it is very important to feel supported by co-workers and the organizational policies. A support system gathered from the peers and management is suggested as one solution. This would provide nurse victims a fair opportunity to process the violent incident and put the event into perspective. (McKoy & Smith 2001, Gates et al. 2011).

6 Discussion

This literature review was done combining narrative review and systematic review. Existing knowledge on workplace violence against nurses and support nurses received after violent incidents was synthesized in this review. The review gives an idea on how much nurses encounter workplace violence and what type of violence is used against them. The review also sheds light on what type of support, if any, nurses received after violent incidents. The results can be utilized by nurses and nursing students, who want more information on workplace violence. It can also be used to develop the support systems available to nurses after they become victims of workplace violence.

Inadequate documentation and severe under-reporting of workplace violence affect the data available on the subject (Howerton Child & Mentes 2010). During the article selection it became clear that due to the issue of under-reporting no completely accurate data on workplace violence would be available. Regardless, this review identifies that a large percentage of nurses face workplace violence during their careers.

Overall the findings of the review were that workplace violence experienced by nurses can take many forms and range from verbal violence to physical violence resulting in serious injury. One factor mentioned contributing to under-reporting was that nurses don't see the need to report violence, when it didn't result in physical injury (Wiley 2007). Despite this, verbal violence and verbal abuse emerged as the most common forms of workplace violence experienced by nurses. Physical violence was less common, with smaller portion of nurses reporting incidents of it. Under-reporting is also a factor affecting the results concerning physical violence, especially when the nurse victims perceive a lack of intent from the part of the assailant, for example when the assailant is confused or demented. When the nurse victim believes that the assailant didn't intent to hurt, they often don't report the incident. (Howerton Child & Mentes 2010).

Assaults and threats with weapons were also reported in the studies, with medical equipment, hospital equipment and furniture emerging as the most common weapons used. While metal detectors and access control would prevent weapons, such as knives and guns being brought in from the outside, they do nothing to prevent the assaults where the weapons used are already in the hospital.

What lies beneath this phenomenon seems to be fear. Management fears that clients/patients might take legal actions if the cases of violence are reported to the authorities. The nurses are afraid of losing their job because they are considered incompetent or to have provoked the incidents. The health care environments foster myths that can, actually, result in victimizing nurses.

When the actual act of violence against nursing staff occurs the support is vital. The findings show that nurses left alone after violent incidents often

suffer from great deal of different emotional problems. A proper support and debriefing could reduce the effects of the sudden crises the violent incident creates. From the article selection included to the review became obvious that in general nurses feel unsupported by their managers and that often the line managers are, in fact, the source of verbal violence and bullying. This leads back to the problem of under-reporting. (Jackson et al. 2002).

6.1 Reliability of the review

The process of making a literature review is demanding. A lot time is consumed due to different phases of the review. (Johansson et al. 2007, 55) The complexity of a literature review shocked the inexperienced reviewers, though a careful familiarization to the subject in advanced helped. As expected by the reviewers, the electronic literature search and article selection was time consuming process. The search of the articles ought to be extensive to minimize literature related bias. In this review the article search was somewhat limited. To avoid language bias, the search was directed to both Finnish and English language articles. (Centre for reviews and Dissemination 2009; Johansson et al. 2007, 53-54).

The process of making a literature review is filled with opportunities for flaws and inconsistencies. However, a literature review is a very competent way of getting an overall picture of specific subject based already existing scientific information. (Johansson et al. 2007, 3). A clear review plan, specific research questions and well defined boundaries helped in conducting the literature review and enhanced the reliability of it.(Johansson et al. 2007, 55) The decisions made by the reviewers during the review process and the phases of the review were consistently documented. The relevance and the quality of the articles were assessed profoundly, so that the articles chosen were able give answers to the research questions.

To produce a reliable review at least two researchers are needed to review and select the materials (Johansson et al. 2007, 6). This particular review was

executed by two reviewers which increased the reliability. The cooperation of several reviewers can be very productive. As a result of the cooperation accurate results are produced and new ideas are born. (Johansson et al. 2007, 55).

6.2 Conclusions

It became evident that the research conducted with more descriptive categories of violence, gave a more accurate picture of how multifaceted the phenomena of workplace violence is. The research articles with only two or three categories provided a quick overall picture of the issue, but resulted in all forms of physical violence from, for example, twisting of arm to rape and violence resulting in injury, be clumped under one category.

With these factors taken into account, the real percentage of nurses experiencing different types of workplace violence can only be estimated. However the review showed that results did not vary significantly from one country to another. This, in part, supports the assumption that workplace violence in healthcare is a global phenomenon.

Solid, standardized reporting procedures would help to provide truer numbers on incidents of workplace violence in healthcare (Howerton Child & Mentes 2010). Also standard definitions of different types of violence and clear instructions on reporting could help nurses to report workplace violence more readily. The incidents of verbal violence and verbal abuse need to be reported as readily as physical violence because of its' potential to psychologically affect the victims (Gates et al. 2011). Proper safety training in regards of how to make a work area safer and self-defense training in both physical and verbal self-defense would lessen the damage caused by violence and quite possibly even prevent some violent incidents, and thus reduce the need to file these reports.

The findings concerning the support in the review are shocking. The pressure not to report the violent incidents by peers and management is great. If the

incidents are not reported, how will the nurse victims receive support? The entire subject seems like a viscous circle.

Open conversation could be an answer to this situation. Management and administration are in a key position on confronting these problems and ought to become sensitive to the matter. Nursing staff needs to have better understanding on their rights to defend themselves and to the right to have safe working environment. (McKoy & Smith 2001).

Large portion of research articles reviewed mentioned that quite often violence against nurses is perceived as “part of the job” (For example; Howerton Child & Mentes 2010 and Jackson et al. 2002). This attitude of acceptance for violence leads to under-reporting of violent incidents as well as lack of support asked for, and received by the nurse victims, with far reaching consequences. A single incident of workplace violence can affect the quality of life of those involved for years to come, and have a negative effect on professional self-confidence of the nurse. The monetary cost of a single incident can also become quite high. To minimize these negative effects of workplace violence nurses and administrators need to stop accepting violence as part of the job. Nurses, as well as the management and hospital administration need to be more aware of the legal rights the nurses have to defend themselves against both verbal and physical assault. Nurses have to have training to acquire the skills to defend themselves and defuse dangerous situations. Management and hospital administration need to know their legal responsibility to provide a safe work environment, and act according to this responsibility. Under no circumstances should violence be just simply part of a job in the healthcare field.

There were no articles on research done in Finland that met the inclusion criteria of this review. Clearly further study on the subject, here in Finland and in other countries as well, is required and highly recommended.

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Appendices

Appendix 1: Table of articles included in the review

	Authors, Country, Year Title	Purpose/Aim/Main topic	Central findings/information
1.	American Nurse USA 2011 *Workplace violence against emergency nurses remains high*	Article on the results of the emergency department violence surveillance study.	Rates of physical violence and verbal abuse against nurses did not decrease between May 2009 and January 2011. 53.4% of nurses reported experiencing verbal abuse from January 2010 to January 2011.
2.	Gates, D., Gillespie, G., & Succop, P. USA 2011 *Violence Against Nurses and its Impact on Stress and Productivity*	How violence from patients and visitors affect emergency department nurses' work productivity, it's relation to nurses' post-traumatic stress disorder.	Workplace violence is a big stressor for nurses and has impact on the care nurses provide.
3.	Chapman, R., Styles, I, Perry, L., & Combs, S. Australia 2010 *Examining the characteristics of workplace violence in one non-tertiary hospital*	To determine the prevalence and characteristics of workplace violence directed at nurses at one non-tertiary hospital. Respondents' reasons for not reporting investigated.	Of the 113 nurses who participated, 75% reported experiencing workplace violence in the previous twelve months.
4.	Howerton Child, R., & Mentes, J. USA 2010 *Violence against women: the phenomenon of workplace violence against nurses*	The consequences of workplace violence, risk factors, nurses receptions of workplace violence, reporting of workplace violence.	Tolerance for violence must end. More research needs to be conducted to make hospitals safer for everyone.
5.	Opie, T., Lenthall, S., Dollard, M., Wakerman, J., MacLeod, M., Knight, S., Dunn, S. & Rickard, G. Australia 2010 *Trends in workplace violence in the remote area nursing workforce*	To assess incidence of workplace violence in the remote area nursing workforce and to compare results to data collected 13 years previously.	Violence most commonly experienced by the nurses was verbal aggression with 79.5% of nurses reporting these incidents. Response rate was 34.6%.
6.	Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. Australia 2010 *Violence toward nurses, the work environment, and patient outcomes*	To relate nurses' self-rated perceptions of violence to the nursing working environment and patient outcomes.	One third of nurses perceived emotional abuse, threats and actual violence rates were lower. Reported violence was associated with increased ward instability. Response rate was 80.3%.
7.	Hills, D. Australia 2008	To report the relationship	Over 76% of the

	Relationships between aggression management training, perceived self-efficacy and rural general hospital nurses' experiences of patient aggression	between nurses' experiences of patient aggression in the previous 3 months, participation in aggression management training and perceived self-efficacy in dealing with patient aggression.	respondents experienced patient aggression within three month period. Response rate was 48.3%.
8.	Wiley, K. USA 2007 *2007 Nebraska Nurses Survey results. Making a world of difference: workplace violence and nursing*	Survey on workplace violence experienced by nurses in Nebraska, USA.	28% of respondents had been verbally assaulted and approximately 25% had been verbally threated by the patients. 154 nurses responded.
9.	Farrell, G., Bobrowski, C., & Bobrowski, P. Australia 2006 *Scoping workplace aggression in nursing: findings from an Australian study*	Report a study of workplace aggression among nurses in Tasmania, Australia.	63.5% of respondents had experienced some form of aggression in the four working weeks prior to the survey. Response rate was 38%.
10.	Hegney, D., Eley, R., Plank, A., Buikstra, E.& Parker, V. Australia 2006 *Workplace violence in Queensland, Australia: the results of a comparative study*	Results on workplace violence study done in 2004 were compare with similar study done in 2001. Purpose was to id the factors impacting nursing work and use the results to inform strategic planning of the Queensland Nurses Union.	The majority of nurses reported experiencing some form of workplace violence. Incidence of workplace violence has increased from 2001 to 2004. Response rate in 2004 was 45%.
11.	Ryan, D., & Maguire, J. Ireland 2006 *Aggression and violence -- a problem in Irish Accident and Emergency departments?*	Explore the trends of violence in Irish accident and emergency departments.	Verbal aggression was experienced by more than 80% of respondents. Response rate was 46%.
12.	Distasio, C., Hall, K. & Beachley, M. USA 2005 *The Maryland Nurses Association workplace violence survey report*	To obtain data on the workplace violence experienced by Maryland Nurses. Determine the effects of workplace violence on the nurses..	Violence is a factor in healthcare workplace. 83% of respondents had experienced verbal aggression and 43% physical aggression. 378 nurses responded.
13.	McKenna, B., Poole, S., Smith, N., Coverdale, J. & Gale, C. New Zealand 2003 *A survey of threats and violent behaviour by patients against registered nurses in their first year of practice*	To survey the threats and assaults experienced by nurses working in different healthcare settings in their first year of practice.	35% had been verbally threatened and 29% physically intimidated. Patient and visitors were the most common source of violence. Response rate was 47%.
14.	Gates, D. & Kroeger, D. USA 2002 *Violence against nurses: the silent epidemic*	Independent study for nurses who wish to learn more about violence against nurses.	Workplace violence is a major public health concern. Most nurses are at risk of violence.
15.	Jackson, D., Clare, J. & Mannix, J. Australia	Explore what is known about workplace violence as it	More manager support is needed and policies to

	2002 *Who would want to be a nurse? Violence in the workplace -- a factor in recruitment and retention*	affects nurses.	improve work environment for all nurses are also needed..
16.	Wells, J., & Bowers, L. United Kingdom 2002 *How prevalent is violence towards nurses working in general hospitals in the UK?*	A systematic search of literature, followed by critical review on how prevalent violence towards nurses is in general hospitals in the UK	The data support a figure of more than 9.5% of general nurses working in general hospitals being assaulted in any 1 year. This includes assault with or without injury.
17.	McKoy, Y. & Smith, M. USA 2001 *Legal considerations of workplace violence in healthcare environments*	To explore some reasons behind underreporting of workplace violence in healthcare. Review legal aspects of workplace violence.	Nurses don't have enough knowledge of their legal right related to workplace violence.
18.	Chovanec-Toy, J. USA 2000, *Professionally speaking. HNA's workplace violence survey indicates need for legislative action*	Congress of Nursing Practice has been investigating this issue of workplace violence. Three separate surveys have been conducted with random populations of Hawaii Nurses' Association (HNA), nurses.	Of those who responded 43% suffered physical assault from patients 60% reported verbal abuse from patient. Response rate was 20.3%.